

	METLIFE		AMERICAN DENTAL PLAN (ADP) Now known as CompBenefits		ORAL HEALTH SERVICES (OHS) Now known as CompBenefits	
Choice of Dentist	Program allows you to choose any dentist you wish. Payments to Preferred Dental Providers (PDP) are based on negotiated fees. Payments to non preferred providers are based on Reasonable and Customary (not billed) charges.		Limited to Participating Dentists in Private Practice		Limited to Participating Dentists in Private Practice	
Maximum Benefit/Deductible	\$1,000 per year per person \$50 deductible per year per person; \$150 family maximum	\$1,500 per year per person \$50 deductible per year per person; \$150 family maximum	No Maximum No Deductible		No Maximum No Deductible	
Type I	STANDARD	ENRICHED	STANDARD	ENRICHED	STANDARD	ENRICHED
	Plan Pays (No deductible)	Plan Pays (No deductible)	You Pay*	You Pay	You Pay	You Pay
0150 Comprehensive Oral Evaluation - New or Established	100%	100%	No Charge	No Charge	No Charge	No Charge
0120 Periodic Oral Exam	100%	100%	No Charge	No Charge	No Charge	No Charge
Xrays	100%	100%	No Charge	No Charge	No Charge	No Charge
1110/20 Prophylaxis	100% (Twice per calendar year)	100% (Twice per calendar year)	No Charge (Once every 6 months)	No Charge (Once every 6 months)	No Charge (Once every 6 months)	No Charge (Once every 6 months)
1203 Flouride Treatment (children up to the age 19)	100%, 1x per year	100%, 1x per year	No Charge	No Charge	No Charge	No Charge
1351 Sealant - per tooth	Not Covered	Not Covered	7.00	7.00	6.00	No Charge
Type II	*	*				
Fillings: (silver)						
2140 one surface	75% Non PDP/100% PDP	75% Non PDP/100% PDP	No Charge	No Charge	No Charge	No Charge
2150 two surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP	No Charge	No Charge	\$11.00	No Charge
2160 three surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP	No Charge	No Charge	\$16.00	No Charge
2161 four or more surfaces	75% Non PDP/100% PDP	75% Non PDP/100% PDP	No Charge	No Charge	\$18.00	No Charge
Root canals:						
3310 Anterior	75%	75%	95.00	95.00	90.00	45.00
3320 Bicuspid	75%	75%	135.00	135.00	155.00	90.00
3330 Molar	75%	75%	175.00	175.00	200.00	145.00
3410 Apicoectomy	75%	75%	65.00	65.00	75.00	65.00
Extractions:						
7111 Single tooth	75%	75%	No Charge	No Charge	No Charge	No Charge
7140 Extraction, erupted tooth or exposed tooth	75%	75%	No Charge	No Charge	No Charge	No Charge
7210 Surgical extraction of erupted tooth	75%	75%	20.00	20.00	15.00	No Charge
Periodontics: (gum treatment)						
4341 Periodontal scaling & root planning-per quadrant	75%	75%	37.50	37.50	40.00	40.00
4210 Gingivectomy/gingivoplasty - per quadrant	75%	75%	105.00	105.00	120.00	90.00
4910 Periodontal maintenance procedures	75%	75%	UCR Less 25%	35.00	25.00	25% Discount
Type III	*	*				
Crown & Bridge						
2930 Prefabricated stainless steel primary tooth	50%	50%	35.00	35.00	25.00	No Charge
2791 Crown full cast predominately base metal	50%	50%	185.00**	185.00**	\$210.00	\$175.00
2751 Crown Porcelain fused to base metal	50%	50%	200.00**	200.00**	\$210.00	175.00
Pontics:						
6210 Full cast	50%	50%	185.00**	185.00**	25% Discount	25% Discount
6240 Porcelain fused to metal	50%	50%	200.00**	200.00**	25% Discount	25% Discount
Prosthodontics (Dentures)						
5110 Complete upper	50%	50%	200.00	200.00	230.00	205.00
5120 Complete lower	50%	50%	200.00	200.00	230.00	205.00
5213/14 Partial upper or lower - cast metal base	50%	50%	250.00	250.00	275.00	240.00
ORTHODONTIA						
Consultation	Not Covered		No Charge	No Charge	25% Discount	No Charge
Evaluation	Not Covered	Adult & Children covered at 50% after a one time deductible of \$50 per person. \$1,000 lifetime maximum	UCR Less 25%	35.00	25% Discount	25.00
Records	Not Covered		UCR Less 25%	250.00	25% Discount	200.00
Children - Normal Class II	Not Covered		UCR Less 25%	1400.00	25% Discount	1,400.00
Adult - Normal Class II	Not Covered		UCR Less 25%	1950.00	25% Discount	1,950.00
8750 Retention	Not Covered		Additional	Additional	25% Discount	25% Discount
VISION						
Examination	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	10% Discount
Single Vision Lenses	Not Covered	Not Covered	Not Covered	Up to 50% off doctor's prices	Not Covered	20% Discount
Bifocal Lenses	Not Covered	Not Covered	Not Covered	Up to 50% off doctor's prices	Not Covered	20% Discount
Trifocal Lenses	Not Covered	Not Covered	Not Covered	Up to 50% off doctor's prices	Not Covered	20% Discount
Contact Lenses - Non-Elective	Not Covered	Not Covered	Not Covered	Up to 50% off doctor's prices	Not Covered	20% Discount
Contact Lenses - Elective	Not Covered	Not Covered	Not Covered	Up to 50% off doctor's prices	Not Covered	20% Discount
Frames	Not Covered	Not Covered	Not Covered	Up to 50% off doctor's prices	Not Covered	20% Discount

*All Type II and III charges subject to annual deducti *The above reimbursements are exclusive of gold.

*STD Plan fee apply to participating General Dentist **Copayments are exclusive of gold.

*Cost of high noble metal additional.